WELCOME
PATIENT INFORMATION

DATE:_____

PATIENT_____ DOB_____/____/ _____

ADDRESS_____ __ _____
street city state zip

SEX: ____M ____ F PATIENT SS#_____ MARITAL STATUS:_____

OCCUPATION:_____

EMPLOYER:_____

_____
street city state zip

EMPLOYER PHONE_____

SPOUSE NAME:_____

BIRTHDATE:_____ SS#:_____

HOME PHONE:_____ CELL_____ E-MAIL_____

WORK_____

IN CASE OF EMERGENCY:_____
NAME

_____
RELATIONSHIP PHONE NUMBER

HOW DID YOU HEAR ABOUT US:_____

MEDICATIONS:_____

ALLERGIES:_____

HEIGHT:_____ WEIGHT:_____

PRIMARY DOCTOR:_____

EXERCISE:____NONE____MODERATE____DAILY____HEAVY

INFORMED CONSENT

Any procedure intended to help may also do harm. While chiropractic examination and therapeutic procedures (including spinal adjustment, ultrasound, heat application, electrotherapy and manual muscle therapy). Are usually considered remarkably safe and effective. Please understand that occasionally there are complications. While the chances of experiencing any of these complications are extremely small it is the practice of this chiropractic office to fully inform and educate all our patients about them. These complications include but are not limited to:

Pain	Disc injury	Burns
Swelling	Senory changes	Soft tissue injury
Bruising	Bleeding	Stroke (CVA)
Discoloration	Bone Fracture	Dizziness
Inflammation	Nausea	Weakness

Worsening of the condition and spinal cord damage:

I understand that there is no guarantee or warranty for a specific cure or result. I understand that I can request further explanation regarding any and all possible risk attendant to my case.

Signature_____

Date_____

Patient Condition

PATIENT NOTIFCATION OF FINANCIAL RESPOSIBILTY

I understand that I may be financially responsible for any charges incurred at this office, Including co-pays, deductibles, and any charges denied or not covered by my insurance company.

I realize that my care may be subject to preauthorization by my insurance company, and I accept all responsibility for any treatments, which are determined not to be medically necessary. I understand that my coverage may not cover routine maintenance, preventative or wellness visits.

In addition, I realize that if I do not have the proper referral that I will be responsible for all charges incurred.

Insurance policy limitations are per individual policy plan, as are co-payments, co-insurance, deductibles and referral policies.

I have read and understand my obligations for payments for the care in the absence of insurance coverage.

_____ _____

PRINT PATIENT'S NAME SIGNATURE patient, parent, or guardian

Female Patients To the best of my knowledge, I am not pregnant and Mid-Hudson Chiropractic has the permission to x-ray my body if necessary.

Patient Signature_____**Date**_____

Patients Under 18 I hereby authorize Mid-Hudson Chiropractic to administer care as they Deem necessary to my son/daughter

Patient's Signature_____**Date**_____

We invite you to discuss frankly with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient. I authorize any holder of medical or other information about me to my doctor, insurance carrier or their intermediaries, any information necessary for my medical care or to process this health related insurance claim.

I hereby authorize payment of benefits to be made directly to Mid-Hudson Chiropractic. I permit a copy to this authorization to be in place of the original. I understand that all fees for services rendered are my responsibility regardless of insurance coverage. All fees not paid by my insurance carrier are to be paid in full by me. I understand that if the account is not paid within 90 days it is my responsibility to either pay the claim myself or to contact the insurance company. I understand it is my responsibility to inform this office of any change in my personal information. (I.e. address, phone number, insurance information, medical status, exc.)

PATIENT SIGNATURE_____DATE_____

NONDISCRIMINATION POLICY

Mid-Hudson Chiropractic Health Services, PC does not discriminate against any person on the basis of race, color, national origin, disability, or age in admission, treatment, or participation in its programs, services and activities, or in employment. For further information about this policy, contact: ***(Dr. Joseph Olmo, Phone: 845-221-3555)***.

5 Personal Injury Questionnaire

Name _____ Phone _____

Nature of Accident :

1. Date of Accident _____ Time of Day _____

2. Were your: ☐ Driver ☐ Passenger ☐ Front Seat ☐ Back Seat ☐ Other _____

3. Number of People in your vehicle? _____ Were you wearing seat belts? _____

4. Were you struck from: ☐ Behind ☐ Front ☐ Left Side ☐ Right Side

5. Approximate speed of your car _____ mph. Other car _____ mph

6. In your own words, please describe accident: _____

_____

_____

_____

7. Did you have any physical complaints BEFORE the accident? ☐ Yes ☐ No If yes, please describe in detail _____

_____

_____

_____

8. Please describe how you felt:

During the accident _____

Immediately after the accident _____

Later that day _____

The next day _____

9. What are your PRESENT complaints and symptoms? _____

_____

_____

10. Do you have any previous illnesses which relate to this case. ☐ Yes ☐ No If yes, please describe _____

_____

_____

11. Have you ever been involved in an accident before? ☐ Yes ☐ No If yes, please describe, include dates, type of accident and injury(ies) received _____

_____

12. Have you been treated by another doctor since the accident? ☐ Yes ☐ No If yes, please list doctor's name and address. _____

_____

What type of treatment did you receive? _____

13. Since this injury occurred, are your symptoms ☐ Improving ☐ Getting Worse ☐ Same

14. Check Symptoms you have noticed since accident:

☐ Headache	☐ Irritability	☐ Numbness in toes	☐ Face flushed	☐ Feet cold
☐ Neck pain	☐ Chest pain	☐ Shortness of breath	☐ Buzzing in ears	☐ Hands cold
☐ Neck stiff	☐ Dizziness	☐ Head seems heavy	☐ Loss of memory	☐ Stomach upset
☐ Fatigue	☐ Back pain	☐ Sleeping problems	☐ Depression	☐ Lights bother eyes
☐ Fainting	☐ Nervousness	☐ Loss of smell	☐ Tension	☐ Pins & needles in arms
☐ Fever	☐ Cold sweats	☐ Loss of taste	☐ Diarrhea	☐ Pins & needles in legs
☐ Ears ring	☐ Constipation	☐ Loss of balance	☐ Ears buzzing	☐ Numbness in fingers

Symptoms other than above _____

15. Have you lost time from work as a result of this accident? ☐ Yes ☐ No If yes, please complete the following questions.

a) Last day worked _____

b) Type of employment _____

c) Are you being compensated for time lost from work? ☐ Yes ☐ No If yes, please state type of compensation you are receiving _____

16. Do you notice any activity restrictions as a result of this injury? ☐ Yes ☐ No If yes, please describe

_____

_____

_____

17. Other pertinent information _____

_____

_____

_____

18. **Attorney**

Name _____ Phone _____

Address _____ City _____ State _____ Zip _____

Patient's Signature _____ Date _____

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
VERIFICATION OF TREATMENT BY ATTENDING PHYSICIAN OR OTHER PROVIDER OF HEALTH SERVICE
(This form is not for verification of hospital treatment)

NAME AND ADDRESS OF INSURER OR SELF-INSURER *

NAME OF INSURER'S CLAIMS REPRESENTATIVE
ADDRESS OF REPRESENTATIVE
PHONE NUMBER OF REPRESENTATIVE

DATE	POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	CLAIM NUMBER

MID-HUDSON CHIROPRACTIC

PROVIDER'S NAME AND ADDRESS *
1033 Route 82
Hopewell Jct., NY 12533
(845) 221-3555

KINDLY COMPLETE AND SUBMIT THIS FORM AS SOON AS POSSIBLE. **PLEASE NOTE COMPLETED FORM MUST BE SUBMITTED TO INSURER NO LATER THAN 45 DAYS OR 180 DAYS AFTER TREATMENT DATE DEPENDING UPON POLICY ENDORSEMENT IN EFFECT AT THE TIME OF THE ACCIDENT.**

IF YOU HAVE PREVIOUSLY SUBMITTED AN EARLIER REPORT ON THIS ACCIDENT, YOU NEED ONLY NOTE ANY CHANGES FROM THE INFORMATION PREVIOUSLY FURNISHED AND ADDITIONAL CHARGES.

1. PATIENT'S NAME AND ADDRESS

2. AGE	3. SEX	4. OCCUPATION (IF KNOWN)

5. DIAGNOSIS AND CONCURRENT CONDITIONS

6. WHEN DID SYMPTOMS FIRST APPEAR? DATE:	7. WHEN DID PATIENT FIRST CONSULT YOU FOR THIS CONDITION? DATE:

8. HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION
☐ YES ☐ NO IF "YES", state when and describe:

9. IS CONDITION SOLELY A RESULT OF THIS AUTOMOBILE ACCIDENT?
☐ YES ☐ NO IF "NO", explain:

10. IS CONDITION DUE TO INJURY ARISING OUT OF PATIENT'S EMPLOYMENT?
☐ YES ☐ NO

11. WILL INJURY RESULT IN SIGNIFICANT DISFIGUREMENT OR PERMANENT DISABILITY?
☐ YES ☐ NO ☐ NOT DETERMINABLE AT THIS TIME
IF "YES", DESCRIBE:

12. PATIENT WAS DISABLED (UNABLE TO WORK) FROM: THROUGH:	13. IF STILL DISABLED THE PATIENT SHOULD BE ABLE TO RETURN TO WORK ON: (DATE)

14. WILL THE PATIENT REQUIRE REHABILITATION AND/OR OCCUPATIONAL THERAPY AS A RESULT OF THE INJURIES SUSTAINED IN THIS ACCIDENT?
☐ YES ☐ NO IF "YES", DESCRIBE YOUR RECOMMENDATION BELOW:

* Bracketed language to be filled in by insurer or self-insurer

CONTINUE ON PAGE 2

VERIFICATION OF TREATMENT BY ATTENDING PHYSICIAN OR OTHER PROVIDER OF HEALTH SERVICE
PAGE 2

15. REPORT OF SERVICES RENDERED

DATE OF SERVICE	PLACE OF SERVICE INCLUDING ZIP CODE	DESCRIPTION OF TREATMENT OR HEALTH SERVICE RENDERED	FEE SCHEDULE TREATMENT CODE	CHARGES
			TOTAL CHARGES TO DATE $	

16. IF TREATING PROVIDER IS DIFFERENT THAN BILLING PROVIDER COMPLETE THE FOLLOWING:

TREATING PROVIDER'S NAME	TITLE	LICENSE OR CERTIFICATION NUMBER	BUSINESS RELATIONSHIP CHECK APPLICABLE BOX		
			EMPLOYEE	INDEPENDENT CONTRACTOR	OTHER (SPECIFY)

17. IF THE PROVIDER OF SERVICE IS A PROFESSIONAL SERVICE CORPORATION OR DOING BUSINESS UNDER AN ASSUMED NAME (DBA), LIST THE OWNER AND PROFESSIONAL LICENSING CREDENTIALS OF ALL OWNERS (Provide an additional attachment if necessary).

18. IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? ☐ YES ☐ NO

19. ESTIMATED DURATION OF FUTURE TREATMENT

(OPTIONAL) 20.
I AUTHORIZE PAYMENT OF HEALTH BENEFITS TO THE UNDERSIGNED HEALTH CARE PROVIDER OR SUPPLIER OF SERVICES DESCRIBED BELOW. I RETAIN ALL RIGHTS, PRIVILEGES AND REMEDIES TO WHICH I AM ENTITLED UNDER ARTICLE 51 (THE NO-FAULT PROVISION) OF THE INSURANCE LAW

PRINT NAME_____ SIGNED_____
PATIENT PATIENT

OR

(OPTIONAL) 21. ASSIGNMENT OF NO-FAULT BENEFITS:
I HEREBY ASSIGN TO THE HEALTH CARE PROVIDER INDICATED BELOW ALL RIGHTS, PRIVILEGES AND REMEDIES TO PAYMENT FOR HEALTH CARE SERVICES PROVIDED BY THE ASSIGNEE TO WHICH I AM ENTITLED UNDER ARTICLE 51 (THE NO-FAULT STATUTE) OF THE INSURANCE LAW. THE ASSIGNEE HEREBY CERTIFIES THAT THEY HAVE NOT RECEIVED ANY PAYMENT FROM OR ON BEHALF OF THE ASSIGNOR AND SHALL NOT PURSUE PAYMENT DIRECTLY FROM THE ASSIGNOR FOR SERVICES PROVIDED BY SAID ASSIGNEE FOR INURIES SUSTAINED DUE TO THE MOTOR VEHICLE ACCIDENT, NOTWITHSTANDING ANY PRIOR WRITTEN AGREEMENT TO THE CONTRARY. THIS AGREEMENT MAY BE REVOKED BY THE ASSIGNEE WHEN BENEFITS ARE NOT PAYABLE BASED UPON THE ASSIGNOR'S LACK OF COVERAGE AND/OR VIOLATION OF A POLICY CONDITION DUE TO THE ACTIONS OR CONDUCT OF THE ASSIGNOR.

PRINT NAME_____ SIGNED_____
(PATIENT) (PATIENT)

PRINT NAME_____ SIGNED_____
(PROVIDER OF HEALTH CARE SERVICE) (PROVIDER OF HEALTH CARE SERVICE)

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

DATE	PROVIDER'S SIGNATURE	IRS/TIN IDENTIFICATION NO.	WCB RATING CODE IF NONE, SPECIALTY

INSURER LIST ADDITIONAL VERIFICATION REQUIRED; ADD SEPARATE PAGE IF NECESSARY
1.
2.
3.
*Bracketed language to be filled in by insurer or self-insurer

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
ASSIGNMENT OF BENEFITS FORM

I, _____(assignor) hereby assign to _____
(print patients name) (print health care provider or hosp.)
All rights, privileges, and remedies to payment for health care services provided by assignee to which I am entitled under Article 51 (the No-Fault statute) of the insurance law.

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained due to the motor vehicle accident which occurred on _____,
(print accident date)
Notwithstanding any prior written agreement to the contrary.

This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack of coverage and/ or violation of a policy condition due to the actions or conduct of the assignor.

AN PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMIT'S A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

_____ _____
(print name of patient) (signature of patient)

_____ _____
(date)

_____
(address)

_____ _____
(name of provider) (signature of provider)

_____ _____
(date of signature)

_____
(address)

PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name _____ Birthdate _____

Signature _____

Date _____

Mid-Hudson Chiropractic Health Services, PC
Dr. Joseph Olmo, D.C.
P.O. Box 86
Hopewell Junction, N.Y. 12533
(845) 221-3555